Mr. LINDER. It is my understanding that any intervening business requires a 15-minute vote on the following vote under the rules of the House, and there was intervening business.

The CHAIRMAN. The Chair will repeat that pursuant to clause 6(b)(3) of rule XVIII, this is a 5-minute vote.

Voting will proceed.

□ 1708

So the motion to rise was rejected.

The result of the vote was announced as above recorded.

Mr. SHIMKUS. Mr. Chairman, I move to strike the last word.

The CHAIRMAN. The gentleman from Illinois is recognized for 5 minutes.

Mr. SHIMKUS. Mr. Chairman, in 1997, a Republican-led Congress passed the State Children's Health Insurance Program, SCHIP, a program that combines the best of public and private approaches to delivering vital health care coverage to low-income children across the country.

Today this program provides coverage to 6.6 million children and has lowered the insurance rate by nearly 25 percent. Unfortunately, our colleagues on the other side of the aisle decided not to include us in crafting the reauthorization of SCHIP. In addition, it included many other provisions affecting Medicare, without any input from the minority.

The legislation put forth by the Democrats has many problems, and I have serious reservations on how they propose to fund this legislation. Specifically, there are proposed funding streams in the bill passed out of the Ways and Means Committee that seek to take money out of end-stage renal disease programs by establishing policies that are shortsighted and ill-advised.

As currently structured, this proposal takes funding from among the sickest patients in the Medicare program, those who have end-stage renal disease, and reallocates it to a massive SCHIP expansion. As a member of the Energy and Commerce Committee, I was pleased to learn that Chairman DINGELL was prepared to offer an amended version of the CHAMP Act that did not include any end-stage renal disease cuts, and, as indicated by CBO score sheets of Chairman DINGELL's amendment, that do not include entries for any end-stage renal disease provisions.

It was unfortunate that the bill was discharged from the Energy and Commerce before amendments could be offered to strike these cuts, but I wholeheartedly agree that we should not be making cuts to end-stage renal disease, which treats some of the sickest patients in Medicare, to fund SCHIP expansion.

As the CHAMP Act currently stands, my concerns with end-stage renal disease are twofold. First, the bill proposes to disrupt the market-based average sales price reimbursement system that Congress worked hard to pass in the Medicare Modernization Act. This average sales price payment system was first implemented in the physician setting in 2005 and the end-stage renal disease setting for all drugs in 2006.

This system has been a great success across the board, and moving to reimbursement rates of ASP plus 6 percent has demonstrated significant savings. In fact, the Office of Inspector General estimated annual savings of $1 billion because of the shift from the old average wholesale price system to the ASP system in 2005.

Starting in 2006, the average sales price system includes drugs used to treat anemia in end-stage renal disease patients, as well as all other end-stage renal disease drugs. MedPACs have noted a decline in end-stage renal disease drug spending since the implementation of the average sales price, and when looking at erythropoietin stimulant agents, which are biologics used to treat anemia in end-stage renal disease, specifically it is clear that the ASP has resulted in a reduction in the price of Medicare, which had previously paid for these biologics going from $10 under a statutory rate in 1994 to 2004.

POINT OF ORDER

Mr. BISHOP of Georgia. Mr. Chairman, a point of order.

The CHAIRMAN. The gentleman will state his point of order.

Mr. BISHOP of Georgia. Isn't it true that the gentleman in the well should be addressing the underlying bill, and it's a violation of the rules if the remarks in the well do not address the underlying bill?

The CHAIRMAN. The gentleman is correct. The gentleman speaking who has the time must confine his remarks to the pending question.

PARLIAMENTARY INQUIRY

Mr. SHIMKUS. Mr. Chairman, a parliamentary inquiry.

The CHAIRMAN. The gentleman will state his parliamentary inquiry.

Mr. SHIMKUS. If there are cuts in one bill based upon increased spending in another, is that financial connection enough to continue to proceed?

The CHAIRMAN. The gentleman must maintain an ongoing nexus between the pending question and any broader policy issues.

The gentleman may proceed.

Mr. SHIMKUS. Starting in 2006, the average sales price system included drugs used to treat anemia and end-stage renal disease patients as well as other end-stage renal disease drugs.

Additionally, there are provisions in the bill that propose to institute a statutory price control rate. It would be a mistake to change a system that has reduced prices for this medicine by 6.8 percent since the average sales price-based reimbursement system was implemented in January of 2006; 9 percent compared to what Medicare paid for the drug back in 1994 under a statutory price control rate.

This market-based system is working to drive down prices for Medicare in Congress, and Congress shouldn't try to fix something that's not broken. Most importantly, I also question how a cut in payment would affect patient care. A payment cut may create financial incentives to reduce or ration clinically beneficial drugs.

Dialysis providers may reduce their costs by providing fewer services and drugs, transferring patients to another setting of care, or discharging patients more quickly.

Mr. Chairman, in 1997 a Republican-led Congress passed the State Children's Heath Insurance Program (SCHIP)—a progam that combines the best of public and private approaches to delivering vital health coverage to low-income children across this country.

Today this program provides coverage to 6.6 million children and has lowered the uninsured rate by nearly 25 percent.

Unfortunately, our colleagues on the other side of the aisle decided not to include us in crafting the reauthorization of SCHIP and in addition, included many other provisions affecting Medicare without any input from the minority.

The legislation put forth by the Democrats has many problems, and I have serious reservations on how they propose to fund this legislation.

Specifically, there are proposed funding streams in the bill passed out of the Ways and Means Committee that seeks to take money out of the End Stage Renal Disease (ESRD) program by establishing policies that are shortsighted and ill-advised.

As currently structured, this proposal takes funding from among the sickest patients in the Medicare program, those that have ESRD, and reallocates it to a massive SCHIP expansion.

As a member of the Energy & Commerce Committee, I was pleased to learn that Chairman DINGELL was prepared to offer an amended version of the CHAMP Act that did not include any ESRD cuts as indicated by CBO score sheets of Chairman DINGELL's amendment that do not include entries for any ESRD provisions.

It was unfortunate that the bill was discharged from Energy and Commerce before amendments could be offered to strike these ESRD cuts, but I wholeheartedly agree that we should not be making cuts to the ESRD, which treats some of the sickest patients in Medicare, to fund SCHIP expansion.

As the CHAMP Act currently stands, my concerns with the ESRD provisions are twofold.

First, the bill proposes to disrupt the market based Average Sales Price (ASP) reimbursement system that Congress worked hard to pass in the Medicare Modernization Act (MMA).

This ASP payment system was first implemented in the physician setting in 2005, and the ESRD setting for all drugs in 2006.

This system has been a great success across the board and moving to reimbursement rates at ASP+6 percent has demonstrated significant savings.

In fact, the Office of the Inspector General estimated annual savings of $1 billion because of the shift from the old Average Wholesale Price (AWP) system to the ASP system in 2005.

Starting in 2006, the ASP system included drugs used to treat anemia in ESRD patients, as well as all other ESRD drugs.